

Medical History

Name: _____ Birth date: _____ Age: _____ Date: _____

Allergies: _____ Married ___ Single ___ Divorced ___ Widow ___

Menstrual History

Age at beginning: _____

Regular: Yes No

Cycle: _____ days (from start to start, now)

How many days? _____

How Light Moderate Heavy

Pains or cramps Yes No

Date of last period: _____

List Pregnancies (include Miscarriages)					
Year	Child's Weight	Sex	Hours of Labor	Anesthesia	Complications

Birth Control Method: _____ Hormones: _____

Past/present genital warts, HPV, herpes, Chlamydia, gonorrhea, HIV: _____

Have had an abnormal Pap smear? Yes No When: _____ Treatment: _____

Any leaking of urine? Yes No When: _____ Treatment: _____

Smoker: Yes No Packs per day: _____ Alcohol: Yes No How much/how often: _____

Caffeine: Yes No How much daily? _____ Helmet usage: Yes No Seatbelt usage: Yes No

Exercise: Yes No How often? _____ Have you ever been physically or sexually abused? Yes No

Have you ever had counseling for any reason? Yes No Drug usage: Yes No

Surgeries: please list what and when

List all medications:

	Date	Results
Last Pap	_____	_____
Mammogram	_____	_____
Colonoscopy	_____	_____
Flex sig or BE	_____	_____
Stool cards	_____	_____
Cardiac risk/lipids	_____	_____
CBC	_____	_____
TSH	_____	_____
UA	_____	_____
Other	_____	_____
Tetanus	_____	_____

